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## Where Were We in 1930?\*

WILLIAM FORD HIGBY, Executive Secretary  
California Tuberculosis and Health Association

Aladdin, he with a magic lamp, and Mark Twain with his *Yankee at King Arthur's Court*, are conspicuous examples of the ability to transfer in time and space. The modern so-called historic novelists are catching on to the knack, but their research largely hinges around female emotions. Their apparent success is probably due to the fact, unsuspected by these novelists, that female emotions are the same, both in time and space.

The period from 1930 to 1948 seems a very short time to a person born in the last century and a very long time for a person born in the 'twenties.

Because life flows along in such a consecutive pattern, major changes in mores, customs, travel and conveniences seem to blend one into another. But if we bring out periods in sharp focus and stop the inevitable flow of time and human events artificially, many surprises await us. As an illustration, let us stop the clock in the early 'nineties. The contrast then and now seem unbelievable, but I think we can also show that in California there are sharp distinctions in our manner of life and our attitudes towards public health between such recent dates as 1930 and 1948.

### THE 'NINETIES

During the early 'nineties, a minority of people lived in cities. Let us look at an average home. A man worked a minimum of 12 hours a day. The mother and daughters worked from before daylight until late at night. The children too, from the time they were five had duties to perform. The theme song of it all was work . . . work . . . work. For centuries, the pattern

of labor in the home was not changed. One of the most revolutionary concepts of man was to dig a well before he built his house, and place the kitchen over the well so that water could be pumped by a long handled pump into a sink. Water, for centuries had been carried in jars and pails.

I well remember when my father made me a little neck yoke, which was a board carved out to fit my shoulders, with ropes attached and two quart pails to carry water. The use of kerosene oil so that you could have a flat wick or a round wick lamp, increased the illumination in homes a thousand percent. But lamps had to be cleaned, and the soot had to be removed from the chimneys with messy results.

A hundred feet from the back door was the ash pile. That was where the garbage and sewage also were piled. But there wasn't very much garbage in those days. Food was too valuable and hard to get. The using of anthracite coal in a base burner stove lightened the task of the man chopping wood and the woman stoking the fire, but still there was labor connected with an inefficient heating plan.

And in the summer were the flies and the insects. And in the fall and in the spring was the mud. Washing, ironing and baking took three days of the week. Washing on the wash board and ironing with an iron that was heated on the top of a wood and coal stove. In the summer babies were dying from "summer complaint." Towards fall children got diphtheria and died. Few of us realize the horrible experience of a child choking to death with diphtheria. In certain areas yellow fever and malaria were uncontrolled. And every summer hospitals and homes were jammed with

\* Presented at the annual meeting of the California Tuberculosis and Health Association, April 1, 1948, Long Beach, California.

typhoid fever patients. Just then, health departments were beginning to function in the area of environmental control. And the rudiments of epidemiology were being formulated, but it was a hard time to live.

But boys and girls were happy. Young maids and young men had high hopes, and old men and old women peacefully lived out their lives with a maximum of ethical ideals.

#### THE 'THIRTIES

Now let us consider 1930. The contrasts are not so great. Most of our people lived in cities or large towns. The age of technology had arrived. We had radio and talking pictures. We had streamlined homes. The birth rate had fallen. We were overbuilt in schools. Our statisticians howled about disasters imminent because of the lack of fertility of our married couples. We were in a depression. The 'twenties had given us some wonderful new hotels and clubs in the big cities, but there were more hard beds and dirty hotel rooms in California than there were good ones.

We had been carried along on the "good roads program" and concrete strips had been built between county seats, but they were narrow and the new high speed automobile had difficulty with them. In the 'thirties you could climb a steep hill with your automobile without boiling the radiator, but you couldn't go very fast because the giant bulldozer had not yet got into operation. It took a very hearty individual to drive from San Francisco to Los Angeles in one day. And there was real adventure in driving from Eureka to Crescent City. The Prunedale cut-off was not in operation; it was an adventure to go from Gilroy to Salinas over the San Juan Grade, and one risked his life in driving from Atascadero to San Luis Obispo. Many can remember the arduous drive from Ventura to Hollywood. Still we complain of the roads we have today, and we complain rightly.

In 1930 we had the beginnings of the Great Depression caused by the collapse in 1929, and we were at the tail end of the great experiment, noble in purpose—prohibition. This great experiment blew up in our faces in 1933 when it was repealed. Looking back, many seem to think that the lack of good liquor in hours of depression, when the harassed ungodly businessmen sought surcease with strong drink, might have been a significant connection.

The mental attitude of the State was one of being sorry for one's self, after experiencing the acceleration of unlimited money and prosperity in the late 'twenties. We began to be plagued with an increasing number of indigent itinerants. Not only transient men, but transient families and transient youths. The railroad officials allowed all these people to ride free on the freight trains because they had learned that sabotage would

follow putting them off the trains. Young girls began to wear trousers and lived in "jungles" with the young men. A moral crisis was upon us. It was alleged that spiritual life had decayed and that the life in the churches was dead.

#### PUBLIC HEALTH IN 1930

Where were we in public health in 1930?

We had a State Health Department which was described as much inferior to the health departments of other states, even though California had been a pioneer in establishing a full-time State Health Department. Its director was underpaid, and his tenure was at the whim of a governor. Governors came and went every four years, and the Health Department was a part of the spoils system.

Our salvation, we thought, was in local health services. Dr. Fred Foard, from the United States Public Health Service, made his headquarters in Santa Barbara and operated on a meager expense account. Then Platt Covington, of the Rockefeller Foundation, with a few thousand dollars to spend in subsidies, was located in Salt Lake City. Dr. William Shepard had demonstrated what local health services could do in Berkeley. Dr. Gillihan was in San Luis Obispo. John Pomeroy, inspired by Herman Biggs, was battling to put an idea across in Los Angeles County. William Hessler was a full-time man in San Francisco and Alex Lesem held down the fort in San Diego. Lee Stone had proved his worth to the citizens of Madera County. Bill Wells kept the public health idea alive in Riverside County and Dr. Main struggled in Santa Barbara. John Sippy had curbed an epidemic in Stockton which made possible the San Joaquin Health District. It is an understatement to say that the theory of local health services was not popular.

There was no question as to the attitude of the California Tuberculosis Association in relation to local health services and a strong State Health Department in 1930. One of the primary objectives of the state association and its delegates, as expressed in its 1930 annual meeting, was to encourage the establishment of full-time health services, because tuberculosis could never be conquered or eradicated without them.

One is led to inquire as to the attitude of doctors and tuberculosis workers towards their problem in 1930. Although the tuberculosis movements started with the stimulation for the building of beds according to the Pennsylvania pattern and stimulation of clinics according to the New York pattern, very early attention was placed upon the child. A large part of the budget of the National Tuberculosis Association and its locals was spent, beginning around 1914, on the Child Health Crusade, motivated by the health fairs. The discovery of so many correctable physical defects

in the draftees of the first world war (where have we heard that since) caused the inauguration of the American child health movement. This was financed largely from New York relief funds collected during the first world war. With almost unlimited funds at their disposal, the founders of this movement established offices and branches in all leading cities of the Nation. The keynote of the campaign was the nutrition of children, the correction of physical defects and the clean tooth which would never decay. When these funds were dried up at their fount, the tuberculosis associations of the country took over. Here was a ready-made formula. Tuberculosis was the foe to youth. It was the greatest cause of death between 12 and 20. Consumption was a wasting away disease. It was coupled with nutrition. The theory was if you could bring children up through the stresses of adolescence, with good strong bodies, with proper nutrition, they would not succumb to tuberculosis. The Emersons and the Cabots in Boston beat the drums of propaganda and trained the experts. Dozens of them descended upon California, and soon no school was in fashion unless all its children were weighed and measured every month. Those who were 10 percent below an artificial average, were the reservoir of tuberculosis breakdown. Nutrition classes were formed, and of course the inevitable institution had to be constructed, which we called preventoria, in which a small fraction of these children could be detained.

Milk had to be supplied. Thousands of dollars of seal sale money went into the furnishing of milk and other nutritious food for these below par children. Millions of seal sale dollars were spent throughout the Nation, and if it did nothing else, it changed the nutrition pattern of the American people. Big, strong husky men in early days did not eat lettuce nor drink orange juice for breakfast, and green and yellow vegetables were the delusions of the crack-pot.

But a day of awakening came. The doctors observed that fat boys and girls 20 percent overweight had as much tuberculosis in a clinical form as skinny ones 15 percent underweight.

It was on the eve of this discovery that we started a program of tuberculosis control—1930. We rediscovered an old truth in 1930. In order to get action in masses of people, emotion probably plays a greater part than reason. We made converts throughout the Nation in our concern for underweight children and their dangers from tuberculosis. When the doctors gave us the scientific facts to show we were wrong, it was difficult to get reason to prevail. An evangelistic spirit of revolt was rampant throughout the Nation and the State. We had oversold an idea that did not happen to be true.

Extreme caution should be our aim from now on in promoting programs of health. The evangelist carries on the ideas of the philosopher who is long dead and whose peers deny his claims. Inaccurate science can become the orthodoxy of decades to come, and to attack orthodoxy is to attack the foundations of civilization.

The twenty-fifth annual meeting of the National Tuberculosis Association was held in Atlantic City in 1929. The keynote of that meeting was childhood tuberculosis. Minneapolis reported through the Limehurst School of the tuberculous, that nutrition had little to do with childhood tuberculosis. The stage was set by Dr. Rathborn of New York, Chadwick of Detroit and Heatherington of Philadelphia. The reservoir of infection was in the schools, and the national campaign based upon these procedures was outlined. A pirquet test was to be made of all school populations. The positive reactor was to be X-rayed. All positive reactors should be traced back into the home, to find the source. It was clear that Von Perke's earlier figures, showing that 90 percent of the population was infected by the age of 20, was not valid in America. School children reacted from 6 percent to 40 percent. In California, the average was about 35 percent. Beginning in 1930 and following the advice of the twenty-fifth annual meeting of the National Tuberculosis Association, the central core of the California program was to tuberculin test and X-ray the positive reactors and search back into the homes for all contacts in all schools. During the next eight years, hundreds of thousands of California school children were tested. At first, in certain areas, as many as 19 reinfection adult type cases of tuberculosis were found per 1,000 school children. In the course of the years, this rate declined, until we came to the point of diminishing returns.

You all know the story that followed. First the use of the fluoroscope; then the invention of the miniature film and the transfer of our activities from the children to the adult as the reservoir of infection.

#### THE ASSOCIATION IN 1930

The question might now be asked: Where were we as an organization in 1930? It will be remembered that until that time, the Executive Secretary of the California Tuberculosis and Health Association was also the Director of the Bureau of Tuberculosis of the State Department of Health, and that a majority of the members of the Executive Committee of the State Tuberculosis Association were members of the State Board of Health. The state organization consisted of persons who paid a dollar a year to belong to the state association, and although local associations were asked to name directors, annual meetings and elections were casual or not held at all. There was conflict between local associations and the state association. The state

association was denied a representative director by the national association. Associations in Los Angeles, San Diego, Orange County, San Francisco, Alameda County and Sacramento went on their way as autonomous units, with very little correlation or intercourse between them. In the rest of the counties of the State, the organization was generally drawn along town lines and schools and Kiwanis Clubs, Parent Teacher Associations, Junior Red Crosses, Principals' Associations and Women's Sewing Clubs had seal sale contracts. A meeting in Sacramento in the fall of 1929 and another meeting in Merced in April in 1930, completely reorganized the state association on a representative and federated basis. Old timers will remember the clash and excitement of those months and they will remember the serene and unperturbed captain of the ship, The Reverend W. H. R. Hodgkin, who steered his craft between Scylla and Charybdis, into the sunshine of the new day. This story can be told in all its details some 20 years from now.

### Colusa County Needs Nurses

Two public health nurses are needed at once to help develop the new public health program of the Colusa County Health Department, reports Dr. A. E. Raitt, County Health Officer. Positions open are for supervising nurse and assistant. Salaries are \$300 and \$275 respectively with an additional 7 cent per mile allowance. And note this—*housing is available in the community.*

Applicants should contact Dr. Raitt directly. His address is Memorial Hospital, Colusa, California.

### San Mateo Examinations

The San Mateo County Civil Service Commission has extended filing dates for three examinations previously announced in this publication.

Last date to file for each of the three following examinations is June 22, 1948.

Position	Examination date
Public Health Engineer.....	July 6, 1948
Chief, Public Health Nursing Service.....	July 7, 1948
Public Health Educator.....	July 8, 1948

Application forms and further information concerning education and experience requirements may be obtained from the office of the Civil Service Commission, Courthouse, Redwood City, California.

For every child a community which recognizes the need and plans for his needs, protects him against physical dangers, moral hazards and disease; provides him with safe and wholesome places for play and recreation, and makes provision for his cultural and social needs.—*From the Children's Charter.*

### Council Recommends Regional Facilities for Institutional Care

Regional facilities for institutional care which cut across state boundaries are recommended by the Western Interstate Committee on Institutional Care of the Council of State Governments.\*

A two-year study of needs and resources in the 11 western states has brought the committee to the conclusion that regional cooperation in the provision of certain types of institutional care will result in financial saving to the states in better facilities and care of patients and students.

The committee points out that the western states have special problems. Nine of the first 10 largest states in the Union are embraced in the 11 western states. The other two states rank 12th and 19th in area.

Eight of the 11 western states are among the 14 in the country having the least population.

In the 11 western states is the greatest proportion of government-owned lands which are not taxable. In one state, government-owned lands constitute 83 percent of the total land area.

Among the recommendations of the committee are:

1. Establishment of a regional high school for the education of deaf students to provide adequate academic, social and vocational training.
2. Cooperative action to provide sight-saving textbooks with 18- to 24-point type to public schools having one or more students in need of such books.
3. Establishment of a regional high school to provide adequate academic, vocational and social training to students having serious visual handicaps.
4. Establishment in the intermountain region, or in the region as a whole, of an institution to provide medical treatment, education and training for children suffering from cerebral palsy. (The California program is referred to as the type of program which is recommended.)

The committee has been instrumental in effecting an agreement with the California School for the Blind in Berkeley to accept from other states children who are doubly handicapped by being both blind and deaf.

While no proposal for a regional institution is made, the committee has recommended to the individual states that separate building be provided for morons, idiots and imbeciles and that competent persons be employed to provide guidance to, and determine placement of, those who are capable of being trained.

A subcommittee is studying the need for cooperation between the states in the care and support of juvenile delinquents.

\*Macfarlane, Grant, "The West Looks to Regional Care," State Government, May, 1948, pp. 102-104.

# State Joint School Health Committee Activities

Progress in the coordination of the public health and school health programs, in the preparation of record forms and teaching materials for use in the schools, and in the formulation of standards to guide administrators of local school health programs, were reported at the meeting of the State Joint Committee on School Health, May 12th.

The committee has been effective during the three years it has been in existence in providing a channel for joint planning and action and for mutual agreement on policy by the state departments of Public Health and Education. Stimulated by the state committee and by the efforts of local school and health department personnel, similar committees have been organized in a number of local communities.

Through the efforts of the state and local committees, much progress is being made in improvement of school and public health programs. In many communities, curricula in health are being strengthened, teachers are being given better preparation in this subject, school health services and the school environment are being improved. Health departments are contributing to the school program and schools are participating in the public health program. The result is that services contributing to the health of the school child, which are primarily the responsibility of the schools, and health services for preschool children and adults, which are primarily the responsibility of health departments, are no longer separate entities but are being amalgamated as two halves of a total community health program.

## WORK IN PROGRESS

**School Health Records.** Under the chairmanship of Dr. Anita Faverman, a subcommittee of the State Joint Committee has prepared and put into trial use during the 1947-48 school year, a Teacher Observation Health Record and a School Medical and Nursing Record. Experimental use of the records will be continued during the 1948-49 school year with increased field consultant service from both state departments in the areas where the records are being used. Special study will be made of the use of the records in secondary schools.

It is planned that the records will be revised at the close of the second year's experimental use on the basis of suggestions made by schools which have had experience with them. Meanwhile, it is hoped that the records can be made available to all schools which wish to use them. Although certain revisions are needed, they have proved a valuable device in implementing the type of

program which fosters a cooperative relationship between the teacher, nurse, physician and parent in meeting the school child's health needs.

**Institute on School Health.** A three weeks' institute sponsored by the two departments will be held at the University of California in Berkeley this summer under the direction of Dr. Dorothy B. Nyswander. It is expected that the group attending the institute may make some revisions in the Teacher's Guide in Health Education for Secondary Schools and it is hoped that work will be done toward the preparation of a guide for elementary schools. Other problems to be considered are: improvement of school health services and school environment, coordination of community resources.

**Administrative Responsibilities.** A subcommittee under the chairmanship of Miss Margaret Cree has prepared a statement on the administrative responsibilities of the local health officer, the school administrator, the teacher and the nurse in the school health program. It is expected that this statement will be in form for publication by fall.

**Checklist on Community Health Resources.** Another publication promised by fall is a checklist on community health resources and a guide for its use prepared by a subcommittee chaired by Mrs. Carol Bloomfield. This publication is being planned for use both in the school health instruction program and by lay adult groups interested in determining how public health services in their communities meet accepted standards.

**Checklist on School Environment.** Mr. Verne Landreth heads another subcommittee which is developing a checklist designed to help schools determine if the school environment is adequate to protect the health of students and faculty. It is planned that this checklist will also be published in the fall.

**Study of Causes of School Absences.** During the spring term of 1947, the state committee sponsored a pilot study of causes of school absences. The study was directed by Dr. Charles Shepard and Dr. Bernice Moss and was financed by the Metropolitan Life Insurance Company. Plans for publication of the study have not been announced.

**Other Work in Progress.** Among other projects which, while not as far advanced as those mentioned above, are the subject of active study by subcommittees are the following:

Standards for vision and hearing testing in the schools.  
Recommendations for physical facilities for school health services, including design, space and equipment.  
Nutrition and the school lunch program.

Record form for use by private physicians in reporting on examinations of children made as part of the school health program.  
Standards for school health sanitation.  
Coordination of school programs of voluntary agencies.

#### **COMMITTEE MEMBERSHIP**

Appointments to the Joint Committee are made annually by the State Superintendent of Public Instruction and the State Director of Public Health. The present membership follows:

##### **From the State Department of Education**

Bertha Akin, Chief, Bureau of Homemaking Education.  
Charles Bursch, Chief, Bureau of Schoolhouse Planning.  
Aubrey Douglass, Associate Superintendent in charge of Teacher Education.  
Frank Doyle, Chief, Bureau of Special Education.  
Ralph Fields, Associate Superintendent and Chief of the Division of Instruction.  
Mabel Gillis, State Librarian.  
Cecyl Havelin, Consultant in Health Education, Chairman of the Joint Committee.  
James Hemphill, Supervisor, School Lunch Program.  
Helen Heffernan, Assistant Chief, Division of Instruction in charge of Elementary Instruction.  
Elizabeth Kelley, Health Education Consultant, Fresno State College.  
Verne S. Landreth, Chief, Bureau of Health Education, Physical Education and Recreation.  
Frank B. Lindsay, Assistant Chief, Division of Instruction, Secondary Education.

##### **From the State Department of Public Health**

Donald Caziarc, Hearing Conservation Specialist.  
Margaret Cree, School Health Nursing Consultant.  
Robert Dyer, M.D., Chief, Division of Preventive Medicine.  
Ann W. Haynes, Chief, Bureau of Health Education, Secretary of the Joint Committee.  
Donald H. Helgren, Consultant in Sanitation.  
Frederic M. Kriete, M.D., Chief, Bureau of Maternal and Child Health.  
George T. Palmer, Consultant in Public Health Administration.  
David Van der Slice, M.D., School Health Consultant.  
Helen Walsh, Supervising Nutritionist.

### **Oahu Health Council**

The active Oahu (Territory of Hawaii) Health Council has undertaken a series of 15-minute radio programs on various public health problems. Scripts for the programs are prepared by members of official and voluntary health agencies in Hawaii.

### **Local Health Officer Changes**

The City of San Bernardino now has a full-time health department operating under Dr. Warren F. Fox. Dr. Fox was formerly health officer of Riverside County. Dr. Finnis E. Wiggins was part-time health officer of San Bernardino.

In other changes recently announced, Dr. James Faulkner replaced Dr. O. T. Wood as health officer of Red Bluff in Tehama County.

The City of Los Banos in Merced County is now under the supervision of the county health department. Dr. L. R. Hillyer was formerly health officer of this community.

### **Registration Executives Recommend New Birth Number and Card**

Recommendations for uniform numbering of birth certificates throughout the United States and a standard birth card for the entire Nation have been made by the American Association of Registration Executives.

The universal birth number suggested for all states would consist of an 11 digit number, of which the first three digits would designate nation and state, the fourth and fifth digits the year of birth, and a six digit number in serial order to designate the individual birth. For example, under the plan, the certificate for the first person registered in a state in 1949 would have the following number: 1XX-49-000001.

The "1" represents the United States and would be found on all birth certificates in this country. The "XX" stands for the particular state in which the birth is registered, each state having its own number. The "49" indicates the year of birth, and the last six digits show the number of the birth in any single year.

Advantages of this system are:

1. The numbers used in all states will be alike in content and make-up.
2. One number only will be assigned to each certificate and this number will never be duplicated.
3. It will be used for life by the individual, even though adopted, legitimatized or otherwise changed in status.
4. It will be the bookkeeping and administrative key whereby all vital records are linked.
5. It is so constructed that the individual and official agencies can easily understand uses and implications of the number.

The adoption of a standard birth card designed by the A.A.R.E. on which the individual's birth number is prominently displayed along with his name, was also recommended for all states.

### **Riboflavin Lost in Sunlight**

Bottles of milk left standing out in the sun lose much of their riboflavin (vitamin B<sub>2</sub>). So reports the Committee on Milk and Dairy Products of the American Public Health Association.

"Seventy-five percent of riboflavin content may be lost during a 3½-hour exposure to direct sunlight. Sunlight has little effect on thiamine (vitamin B<sub>1</sub>) or vitamin A," the report stated.

In our efforts to attain better health, we must not only seek to prevent disease—we must make every effort to improve what is now accepted as average health.—Thomas Parran, M.D.

## 100 Percent Whole Wheat Bread Still Best "Staff of Life"

That bread is the "staff of life" has long been accepted as axiomatic. During the past decade, however, nutritional studies have indicated that in the United States many of us chose a "staff" which is far weaker than is desirable.

Most of this will be quite familiar to readers of *California's Health*. One could not be associated with public health for long without hearing of the virtues of whole wheat bread over the ordinary white variety which so seems to please the American palate. Although it may seem strange to future students of our society, we now take ordinary wheat, subject it to a milling process which deprives it of much of its B-complex vitamin and mineral content, and then add the nutrients which we have taken out and proclaim our bread as "enriched." The catch in all this, of course, is that it is not possible for us to know exactly what or how much we have taken out to begin with. We therefore end up with an "enriched" product which is considerably less nutritious than the material with which we started.

To a certain extent the nutrition education and publicity campaigns which were at a high pitch during the recent war were successful in putting across the idea that "dark" bread was better than "white" bread.

What the nutritionist meant by "dark" was 100 percent whole wheat bread. Many a consumer, however, was led to believe that loaves labeled "wheat" or "cracked wheat" which are also dark in color satisfied the requirement. Unfortunately, this is not the case. Ordinary dark bread consists of 30 percent whole wheat flour and 70 percent nonenriched white flour. A recent study at the Pennsylvania State College found this bread to be inferior nutritionally to both 100 percent whole wheat and white enriched flour types.

Five types of bread were compared in the Pennsylvania experiment.

1. 100 percent whole wheat bread.
2. Nonenriched white bread.
3. Enriched white bread.
4. Nonenriched white bread containing 6 percent dry skim milk.
5. Ordinary dark bread (30 percent whole wheat flour and 70 percent nonenriched white flour).

The results showed that 100 percent whole wheat and enriched white bread were far superior to all the others, the poorest being nonenriched white.

Nonenriched white with added skim milk and ordinary dark bread were inferior to whole wheat and enriched white in thiamine and niacin.

The skim milk bread was inferior to enriched white in riboflavin despite the milk content of the former. The skim milk white bread, however, would contain more calcium than any of the other breads and its protein value would be somewhat improved.

All of which seems to mean that 100 percent whole wheat bread is still the best "staff of life." Although not as good nutritionally as whole wheat, enriched white bread is superior to ordinary dark bread which is merely labeled "wheat" or "cracked wheat" and which contains as its major component nonenriched white flour.

## W.H.O. an Actuality—U.S. May Join

The World Health Organization became a reality on April 7th of this year when the twenty-sixth member nation of the United Nations ratified the constitution.

The W.H.O. is the first specialized agency of the United Nations of which the United States is not a member. However, it appears at this writing that Congress will authorize U. S. membership before its summer adjournment. Last July a bill to this effect was passed by the Senate and reported favorably to the House of Representatives. Since that time, the bill has been held up in the House Rules Committee. Certain parliamentary moves have been taken in the past month which, according to the *Bulletin* of the Social Legislation Information Service, will result in clearance of the bill of the Rules Committee for debate and action by the full house.

## Oakland Sanitarian Examination

The Oakland Civil Service Board has scheduled an examination for *District Sanitary and Food Inspector*. Last date on which to file is June 25, 1948.

A valid certificate of registration as a sanitarian issued by the California State Board of Public Health is required.

Application forms and further information are available from Room 323, City Hall, Oakland, California.

Public health succeeds, or fails, according to the extent that it succeeds in reaching the people and educating them concerning its aims, purposes, and its methods of procedure.—*Wilson G. Smillie, M.D.*

### Los Angeles Crippled Children Camp

The Los Angeles Society for Crippled Children has announced the acquisition of its own campsite for crippled children summer activities and is building facilities which will be ready by early summer.

Children from other areas will be accepted if applications are made through local crippled children societies. Any local society wishing to send campers should communicate with Mr. Howard Miller, Executive Secretary, Crippled Children's Society of Los Angeles County, Inc., 325 West Adams Boulevard, Los Angeles 7.

### Report Shows Population Density Rise in State and Nation

Population density, the number of persons per square mile of land area, has increased nearly 90 percent in the United States since the beginning of the century, reports the *Statistical Bulletin*.\*

Every state in the country showed an increasing population density between 1900 and 1947. California in 1900 was the 38th most densely populated state. By 1947, however, its rank was 18.

Focusing attention on the changes since 1940, the article reveals that the density of population actually decreased in 11 states, most of which are located in the South Central States and Great Plains area. "The situation reflects," it is stated, "the accelerated movement of population in recent years from farm to non-farm and to urban areas. Our people tend more and more to concentrate in industrial centers. Even in the Southern States, which have experienced heavy out-migration, the urban population has grown rapidly since 1940. In fact, between 1940 and 1947 the urban population of the United States increased 12.7 percent, the rural nonfarm population increased 14.3 percent (largely from growth of suburban areas), whereas the farm population fell 9.6 percent."

Density of population for the United States and California (number of people per square mile of land area) for the 10-year periods between 1900 and 1940 and for 1947 is as follows:

	1900	1910	1920	1930	1940	1947	since 1947— since 1900
United States -----	25.6	30.9	35.5	41.2	44.2	40.2	88
California -----	9.5	15.3	22.0	36.2	44.1	63.0	30

\* Statistical Bulletin, Metropolitan Life Ins. Co., March, 1948.

### California Morbidity Reports

#### Selected Diseases—Civilian Cases

Total Cases for April and Total Cases for January Through April, 1948, 1947, 1946 and 5-Year Median (1943-1947)

Selected diseases	Current month				Cumulative			
	April				January through April			
	1948	1947	1946	5-yr. median 1943- 1947	1948	1947	1946	5-yr. median 1943- 1947
Chickenpox (varicella)-----	7,053	6,796	4,173	6,045	23,060	22,510	13,741	12,221
Coccidioidal granuloma-----	5	13	-----	-----	18	25	13	13
Conjunctivitis—acute infections of the newborn (ophthalmia neonatorum)-----	3	4	2	7	8	14	12	12
Diphtheria-----	31	74	74	74	213	380	471	471
Dysentery, bacillary-----	26	11	10	10	100	45	57	57
Encephalitis, infectious-----	5	2	5	7	18	12	11	11
Epilepsy-----	130	174	131	131	639	613	528	528
Food poisoning-----	15	40	18	18	40	156	124	124
German measles (rubella)-----	682	358	2,876	1,715	1,032	7,098	7,098	7,098
Influenza, epidemic-----	135	209	176	138	13,780	571	5,046	5,046
Jaundice, infectious-----	1	16	18	18	28	48	77	77
Malaria-----	10	50	10	10	12	41	324	324
Measles (rubeola)-----	14,682	1,050	15,864	5,860	31,207	3,832	35,953	35,953
Meningitis, meningoococcal-----	20	33	38	80	168	129	273	273
Mumps (parotitis)-----	4,663	2,659	2,688	2,924	13,150	8,028	9,999	9,999
Pneumonia, infectious-----	130	184	179	288	688	874	1,190	1,190
Poliomyelitis, acute anterior-----	10	34	19	19	55	207	117	117
Rabies, animal-----	26	32	53	79	127	111	155	155
Rheumatic fever-----	71	107	50	50	319	321	240	240
Scarlet fever-----	365	639	746	746	1,554	2,500	3,057	3,057
Streptococcal sore throat-----	43	79	-----	-----	233	263	-----	-----
Syphilis (variola)-----	-----	-----	-----	0	2	7	7	7
Tuberculosis:								
Pulmonary-----	643	1,073	687	687	2,736	3,147	2,431	1,318
Other forms-----	44	60	37	37	186	202	187	187
Typhoid fever-----	9	12	11	11	44	30	44	44
Typhus fever-----	2	-----	3	-----	5	10	10	10
Undulant fever (brucellosis)-----	10	33	23	23	43	86	94	94
Whooping cough (pertussis)-----	418	1,345	312	1,345	1,829	3,110	1,733	1,733
Venereal Diseases:								
Chancre-----	41	54	58	58	167	223	158	158
Gonococcus infection-----	2,232	2,823	2,551	1,931	9,110	11,247	10,201	10,201
Granuloma inguinale-----	4	9	4	4	19	32	10	10
Lymphogranuloma venereum (lymphopathia venereum, lymphogranuloma inguinale)-----	31	23	17	17	106	83	66	66
Syphilis-----	1,624	2,096	1,982	2,096	6,204	8,557	7,993	7,993

### Syphilis Mortality Declines

Reported syphilis mortality in the United States has decreased for 11 consecutive years, according to Public Health Service statistics.

Since 1933 when a mortality rate of 16.2 deaths per 100,000 population was recorded, the rate has declined with each successive year. The 1947 death rate for the disease in the United States was 8.7 (estimated).

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